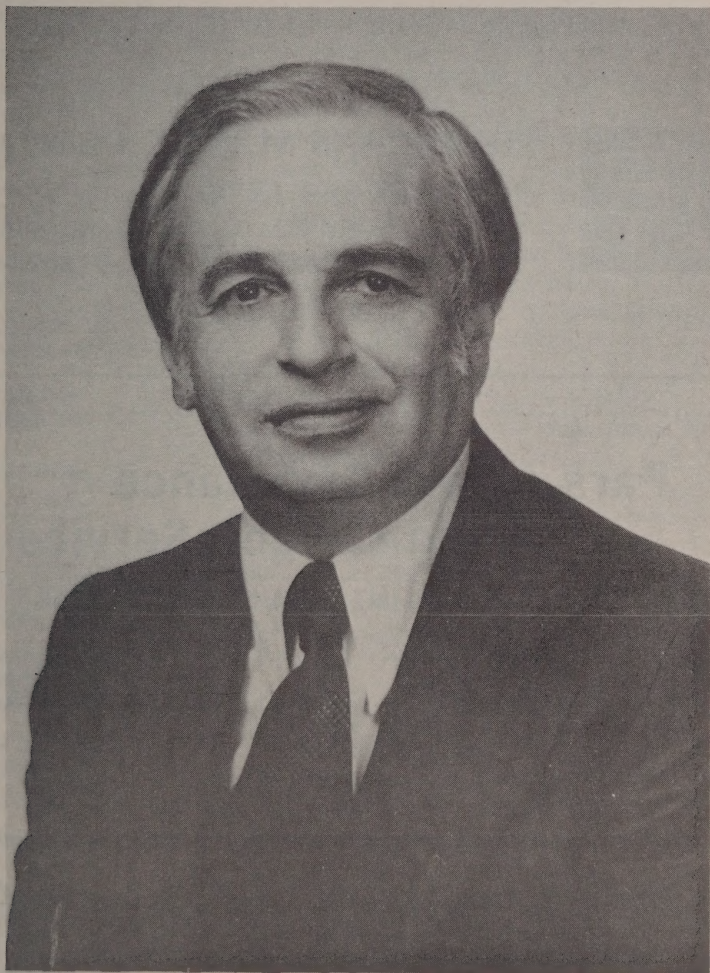


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JUNE/JULY
1975



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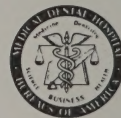
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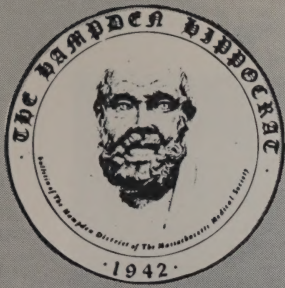
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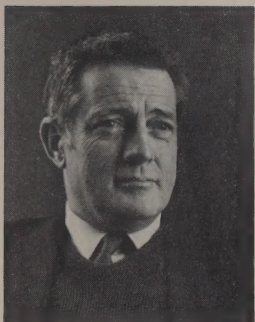
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Your President's Page



P.S.R.O.

Fellows, by now you have all received a letter from the secretary of the H.E.W. stating that he is considering for conditional status the Health Care Foundation of Western Massachusetts as a designated P.S.R.O. for the Western Massachusetts Region I area. He goes on to state that if any of the physicians have an objection toward this organization being the representative for them as P.S.R.O. that they notify the secretary and that if there is a sufficient number of objectors that he will appoint some other organization to do the job.

This notification is required by the P.S.R.O. law that is basically necessary to fulfill the requirements of that law prior to the secretary's appointing a conditional P.S.R.O. in our region. It is also worth mentioning the Health Care Foundation of Western Massachusetts is a foundation of our district and the other medical societies in need Region I have developed for the very purpose so stated. It also seems only fair to state that there appears to be some controversy present between separate sections of the H.E.W. in Washington that is Social Security Administration in the bureau of Quality Assurance a sort of "tug of war" for power in this upcoming Quality Control program. Under the present P.S.R.O. law hospitals can in fact continue to run their own utilization review with only surveillance by the regional P.S.R.O. for quality of care, if the hospital does not wish to continue to run its own utilization review it can ask the P.S.R.O. to do it for them.

It is also in the law that this program unless it is specifically delayed is to be ready for operation by 1 January 1976 and to show that it can in fact do what is required in the P.S.R.O. law.

As many of you know the Health Care Foundation of Western Massachusetts and its P.S.R.O. corporation has developed and is now putting into place in each hospital a utilization review mechanism which fulfills the requirements of H.E.W. While governmental interference for the practice of medicine is not to our liking I would feel at least that this regional P.S.R.O. does provide us with an input area that will allow us to have a voice in the operation of management as the program gears up.

The Hippocrat will contain articles from the Health Care Foundation of Western Massachusetts in the next few issues. They will be directed towards the changes over the commencement of this program.

It is the sincere hope of your district president that any and all questions and problems that arise can be handled locally and we would like to stand ready, along with the Health Care Foundation, to try and solve these problems as they come up.

I feel that this is a year of transition for all of us and that we may in fact all feel somewhat threatened before we finish the year by this new supervised reorganization, but it is basically your organization and with your collective working with it and controlling of it you can determine its course.

Gardner Cox, II, M.D.



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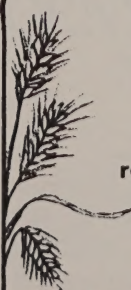
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Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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Brief Summary of the Executive Committee Meeting June 10, 1975

The minutes of the May meeting were read by Mrs. Purdy and accepted as read.

The correspondence included a letter from A.M.A. to Dr. Bloom regarding participation of Western Massachusetts physicians as members in the A.M.A. The Massachusetts Medical Society notified the HDMS that one of its members had failed to pay his dues and therefore was being dropped from the MMS.

Old business—a representative will be appointed to the Valley Dental Association, and an alternate to the Public Relations Committee will be appointed. The result of the invitation by the Society to interns and residents in training in three area hospitals was discussed. A new proposal before the legislator regarding liability was discussed. Application for membership in the society was approved for Dr. Foster. Dates of the upcoming year's district meetings, places and speakers were discussed. An Ethics and Discipline committee will be organized through the committee chairmanship of the Vice-President of the HDMS. A physician will be appointed to the Home Care Task Force under the auspices of the Western Massachusetts Health Planning Council. Application by Mercy Hospital for reconsideration of the certificate of need for a new addition was reviewed. The Arbitration Plan as approved by the HDMS and the Hampden Bar Association will be discussed at the September meeting. Finally, the meeting of the rules and regulations pertaining to three man group practice and the certificate of need necessary for the establishment of such a clinic will be discussed at a Westfield State Hospital meeting at 1:30 in the afternoon, June 20, 1975.

The chairman of the By-Laws committee will determine the viability of the Mental Health Committee. Motion for adjournment was made and seconded.

Respectfully submitted,
Philip B. Stoddard, M.D.

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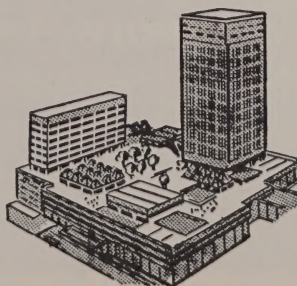
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Report of Medico-Religious Seminar

On April 28, 1975, approximately 25 clergymen and physicians gathered to participate in a seminar on the general topic of the doctor-patient-clergy relationship, with a discussion of ethics, of values, of information sharing, and of problems of confidentiality.

Rev. Gary DeLong of Longmeadow stated that rapport among physicians and clergymen develops with daily contact, particularly in reference to a patient who is seriously ill, but that such contacts were unusual in Springfield. He feels, however, that clergymen are often better able to talk with the dying than the average physician. He pointed out that many cancer patients need pastoral care to help them through the anger and hostility phase.

Dr. Bloom agreed that patients often need clerical help in getting their minds straight during difficult illnesses. He spoke of the patient's right to information on the chart, and the necessity of walking the narrow line between recording events and opinions or progress and recording information which might become damaging to the physician. He also mentioned that a patient with cancer may be helped, even though not cured. Privileged information may be shared only when authorized by the patient.

Rabbi Harris Gendalia, who is also a lawyer, pointed out that patients often report health problems to them, with an implied promise that this knowledge will not be disclosed unless the information seems especially important to the patient's care. The patient should be told of the intent to disclose, and who will receive the information.

Dr. Teale proposed that we effect a method of communication which would be mutually helpful. The recent establishment of hospital based clergymen at Western Massachusetts Hospital Center with a chaplaincy program was reported. It was proposed that every hospital should have such a program, and that explanation of counseling service might be made at a hospital staff meeting. Hospital administrators have not generally appreciated the value of cooperation with the clergy. Mention was made of what often has seemed to be invaluable service by a clergyman in the ER.

There was a general feeling of understanding and interest in working together on the part of all present, and a repeatedly expressed desire for further discussions and implementation of an improved relationship among all professionals.

Respectfully submitted,

L. W. Whiting, Chm.

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With the eyes of most American now trained on the economy, those organizations concerned with economic development—primarily Chambers of Commerce—are also in the national focus and facing their greatest challenges in years.

In the Springfield area, the Greater Springfield Chamber of Commerce is launched upon its own campaign to "Keep Springfield Moving" and doing so through the help of hundreds of business, industrial, and professional people.

The local Chamber has a history of adjusting its program priorities to suit economic and social conditions in the community. Its human development department came about through just such a process several years ago. And since that time, it has made substantial contributions to the areas of housing, minority enterprise, consumer credit, neighborhood organization, job training, education, and human relations.

The development of human resources is still an area of concern and one of three categories of activity in which the Chamber will concentrate its efforts this year.

The two remaining areas are economic development and governmental affairs.

Economic development has been one of the strongest points in the Chamber's program for years. Through its non-profit corporation, the Springfield Area Development Corp., it has undertaken the development of four industrial parks—Memorial, Progress, East Longmeadow, and Industry East—and will be taking on the new West Springfield Industrial Park this year. In addition, it is developing the Pynchon Food Center, and has constructed several industrial facilities for lease to growing companies.

(Memorial is already fully developed, and Progress and the Food Center will achieve maximum development within weeks.)

Retaining those firms already a part of our Springfield area economy continues to be a major function of the Chamber, along with all projects with potential for improving the climate for conducting business in this community and state.

Because that economic climate is so dependent today upon the acts of state government, the Chamber conducts a vigorous legislative program, constantly monitoring those bills which would affect business and community development, taking public stands on key issues, conducting programs with legislators, including bi-weekly coffee hours, meeting with legislators in Boston, and operating continually a communications network between its members and legislators for expressing support or opposition to business legislation.

To remain internally strong, with the volunteer and financial support necessary for attaining its goals for the economy and the community, the Chamber has this year another priority: that of increasing its base of support within the business and professional sectors.

Volunteer leadership of the Chamber this year is headed by President Gerald M. Ellsworth, plant manager of Monsanto Co.

In all of its programs, the membership is aided by a professional staff of 20 people, directed by the Executive Vice-President.

Chamber offices are located on the plaza level of Valley Bank Tower.

Paul J. Greeley
Executive Vice-President



M.M.S. President's Message: Of Time, Strength, Ability, Unity And Participation

It is interesting to note that on May 11, 1781 a bill to incorporate certain physicians into the Massachusetts Medical Society was read into the House of Representatives of the State Legislature.

The American Revolution ended five months later on October 19, 1781. And, on November 1, 1781 Governor John Adams signed the Society bill into law.

That the Society was delivered in troubled times is evident. That there was such business as usual while the country was at war is amazing, as is the fact that five of the fourteen founders of the Society were pro-British and not particularly popular.

Despite the turmoil and despite the obvious differences of opinion among the fourteen founders, there was an evident unity and participation.

—Which brings me to my theme for the year: *Unity and Participation*. Unity, despite differences; and participation that the Society "be preserved and its influence be enhanced among the people."

On the occasion of his receiving the gold badge of 50-year membership, May 20, 1952, Ralph R. Stratton, M.D. (1874-1955) of Middlesex East, my mentor, my Chief of Surgery at Melrose-Wakefield Hospital said:

"For fifty years we have been members. For fifty years we worked. For fifty years we have accepted the protection of the Society. We have been granted all its privileges, not only as members but also in our association with other societies and with the reception of favors and honors that could not be obtained in any other way than by our membership here.

"Years ago I happened to read a little article in what was then the Principles of Medical Ethics of the American Medical Association and it spoke as follows: and a physician shall give of his time, his strength, his ability to the affairs of the society of which he is a member in order that the honor and dignity of that society be preserved and its influence be enhanced among the people.

"We oldsters have tried to carry that out, and as oldsters and recipients of your kindnesses today and in appreciation of this accolade, which we will prize, we want to return a present to you. We want to offer a challenge to you young men, undergraduates, that you see to it that by your time, your strength, your ability, you protect and enhance the honor and dignity of this our society of which its founders and our forebears have been so justly proud."

Thank you, Dr. Stratton.

Louis F. Alfano, M.D. President
Massachusetts Medical Society
1975 — 1976



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Editorial: A New Beacon for Beacon Hill??

Governor Dukakis has proposed that the Commissioner of Public Health need not be a physician. This from the state which led the nation in Public Health concepts and programs for more than a century, is a turnabout that many physicians find difficult to understand. Perhaps, the Governor's proposal will at least stimulate our thinking about "Public Health" and lead to worthwhile revisions in concepts from which all citizens will benefit. The medical revolution in which we find ourselves requires at least two qualities in a Commissioner of Public Health:

1) A strong hand to hold course as the various areas of pressure and counterpressure strike our ship of medicine and 2) a strong mind which can see not only the horizon, as marked by the compass, but which can see beyond the horizons onto a harbor of medical ease and good health for all. The Governor may find such a single individual but probably two men, one versed in traditional medicine and public health and another an expert in administration and knowhow of interpreting governmental edicts and regulations, will fill his requirements. The Armed Services during World War Two developed the deputy or administrative assistant, perhaps this concept can be brought into the department of Public Health, too.

For the physician team member, one trained in Public Health would (obviously) be ideal. This individual could also involve himself with or in the Commonwealth's School of Medicine in Worcester. This educational asset could and *should* become the center of training, research and development in Public Health and public health ideas. It should provide the knowhow to the departments and sections dealing with the public's health in the Commonwealth. Ideally, the Commissioner should be part of the faculty of a state supported school of Public Health, integrated with its medical school.

There appear to be at least five areas of concern for any individual selected as Commissioner. (The reader may wish to add more to the list and he or she are so invited.)

1. *Active—Deliverable Health Care*
 - a) Medical practice—acute and chronic disease
 - b) Hospital medicine and outpatient practice
 - c) Non-acute care facilities (i.e. nursing homes, etc.)
 - d) Structured systems as H.M.O. and Clinics
 - e) Institutional/custodial care, both public and private
 - f) Ancillary services, food programs, voluntary health organizations

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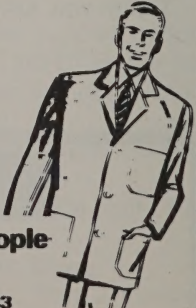
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2. *Industrial Health Care*

- a) Health maintenance of the active work force
- b) Migrant workers health
- c) Fishing industry, farming and restaurant business
- d) Inplant hygiene and pollution and safety
- e) Hazard and accident survey, direct and indirect involvement

3. *Community Health Care*

- a) Public and private school systems, all levels
- b) Community planning and ecologic impact studies
- c) Environmental stress and psychologic impact studies
- d) Coordination of federal and state health care systems
- e) Adequacies (quantity & quality) of personnel and equipment for each community Regional Health Planning Councils

4. *Welfare and State Supported Health Care Programs*

- a) Medicaid, old age assistance
- b) Soldiers Homes and hospitals
- c) Commonwealth hospitals and health institutions
- d) Special areas of concern—maternal health, venereal disease, etc.
- e) Federal/state programs, Model Cities, Food stamps, Workmens' Compensation
- f) Penal systems health programs
- g) Visiting foreigners and "quarantine stations"

5. *Standards of Present Day Public Health Care*

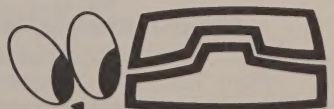
- a) Current Department of Public Health
- b) Epidemic and endemic disease control
- c) Pollution control air, water and soil
- d) Recreation and Tourist health and safety.

Therefore the grasp and knowledge of the new commissioner must be strong, broad, enthusiastic (tempered by experience), openminded and dedicated to the **public's health**. Medical training granting an M.D. and public health training granting a Ph.D. seem mandatory to provide him with the necessary knowledge and competence to appraise the problems and develop solutions. An individual with at least a master's degree in administration could provide the balance needed to "run" the department. Appropriate department heads in the medical school and/or its school of public health could provide the sectional or divisional knowledge and methodology to assist in the affairs of the department. The Hippocrat readers are urged to pass along your ideas to the Board of Editors, the Department of Public Health or Governor Dukakis.

Editor's Note: The Governor has just appointed a young physician as his new commissioner.

Editor-in-Chief
June 1975

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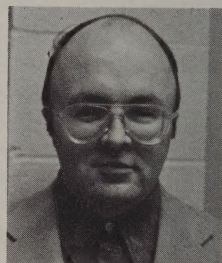
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New Members - June 1975

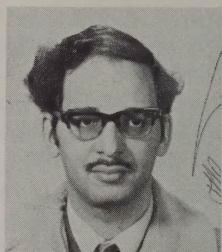
Arnold L. Case, M.D., 110 Maple St., Springfield, MA. Born: Feb. 22, 1934. Medical School: George Washington University, 1960. Internship: District of Columbia General Hospital, July 1960-June, 1961. Residency: Rochester General Hospital, Rochester, N.Y., July, 1961-June 1964. Specialty: Obstetrics and Gynecology.



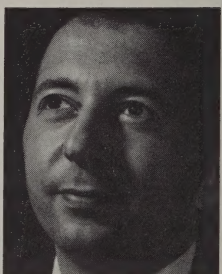
Hammond C. Collins, M.D., 535 Allen St., Springfield, MA. Born: April 29, 1940. Medical School: University of Maryland, 1966. Internship: New England Medical Center Hospital, Boston, 1966-1967—straight surgery. NEMCH 1st year surgery. Residency: Tufts-Boston—Orthopedics H. Banks, M. D. 1970-1973. Specialty: Orthopedic Surgery.



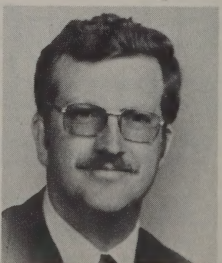
Peter Francis Giraud, M.D., 42 Ridgewood Terrace, Springfield, MA. Born: Nov. 14, 1938. Medical School: University of Louvain-Belgium, 1967. Internship: Hotel—Dieu of Montreal and Affiliated Hospitals (Misericorde, St. Justine). Residency: San Juan Municipal Hospital, Ob/Gyn 1st year. Berkshire Med. Center, Pittsfield, MA. Ob/Gyn 2nd year. Wesson Women Hospital, Springfield, MA. Ob/Gyn 3rd year—Chief resident. Specialty: Ob/Gyn.



Benjamin M. Ianzito, M. D., 444 Montgomery St., Chicopee, MA. Born: Feb. 28, 1942. Medical School: Tufts 1968. Internship: Rhode Island Hospital, 1968-1969, Mixed medical. Residency: St. Louis, Mo., Barnes Hospital 1969-1972 (Washington University School of Medicine)—Psychiatry. Specialty: Psychiatry.

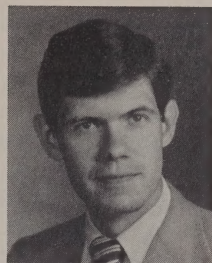


Philip J. Keating, M. D., 27 Pidgeon Drive, Springfield, MA. Born: April 13, 1937. Medical School: University of Liverpool, 1960. Internship: St. Agnes Hospital, Baltimore, MD. 1960-1961. Residency: Walter Reed General, 1964-1964. Massachusetts General Hospital 1967-1968. Specialty: Anesthesia.

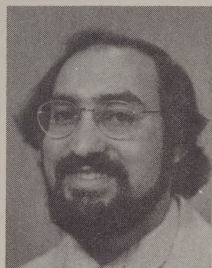


New Members - June 1975

Thomas J. Keenan, M. D., 125 Liberty St., Springfield, MA. Born: June 20, 1942. Medical School: Medical College of Virginia, 1969. Internship: St. Luke's Hospital Center, New York, N. Y. 1969-1970. Residency: St. Luke's Hospital Center, New York, N.Y. 1970-1974 (2 yrs. in Clinical Cardiology, 1972-1974). Specialty: Internal Medicine and Cardiology.



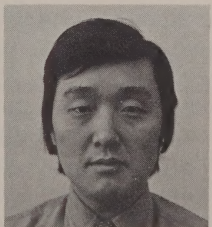
Jeffrey A. Lane, M. D., Medical Center of Western Massachusetts, Springfield, MA. Born: April 3, 1949. Medical School: Hahnemann Medical College, 1974. Internship: Medical Center of Western Massachusetts, Rotating.



Arthur T. McGuire, Jr., M. D., 780 Chestnut St., Springfield, MA. Born: March 27, 1938. Medical School: Tufts, 1964. Internship: Philadelphia General Hospital, Philadelphia, 1964-65. Residency: Philadelphia General Hospital, Philadelphia, 1968-70. Specialty: Internal Medicine and Gastroenterology.



Won Chang Park, M. D., Medical Center of Western Massachusetts, 759 Chestnut St., Springfield, MA. Born: Feb. 12, 1939. Medical School: Soo-Do Medical College, 1964. Internship: Swedish Hospital at Minneapolis, Minnesota, 9-10-64 to 9-10-65. Residency: Radiation Therapy at Memorial Hospital for Cancer & Allied Diseases in New York City 9-10-65 to 6-30-68 3 years. Diagnostic Radiology at above hospital 4th year 7-1-68 to 6-30-69. Specialty: Radiation Therapy.



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Featured Article: Hypertension

May 1975 was designated as National Hypertension month by the United States Public Health Service and a number of cooperating agencies. No physician needs to be told how widespread is the problem of hypertension. It is encountered daily in the practices of virtually all physicians who provide primary care. It strongly predisposes to the development of atherosclerosis and other degenerative diseases of blood vessels such as dissecting aneurysm of the aorta. Hypertension has long been known to be a precursor of congestive heart failure, although there has been much debate about the relative importance of the hypertension per se and the coronary atherosclerosis which is induced or accelerated by the presence of hypertension. The report from Framingham (New England Journal of Medicine Vol. 283, October 19, 1972 page 781) was somewhat surprising in that it implicated hypertension as the precursor in 75% of all cases of newly developed congestive heart failure. Furthermore, this study and others from Framingham and elsewhere have pointed out that systolic hypertension (160 mmHg. or greater) is just as ominous as diastolic hypertension (95 mmHg. or greater).

We now have an almost baffling array of antihypertensive drugs, and we know that at least in some instances we can control hypertension. Until recently, however, we did not know whether control of hypertension would prevent the complications of hypertension. A rigorous and well-controlled project done by the Veterans Administration Cooperative Study Group on antihypertensive agents showed that control of hypertension does indeed prevent complications of hypertension, at least in middle-aged males. (JAMA 202:1028, 1967 & 213:1143, 1970.) Congestive heart failure, dissecting aneurysms, stroke and malignant phase of hypertension were almost completely prevented in those patients who received therapy. It is important to note that control of hypertension in the middle-aged population probably has little or no effect on the incidence of myocardial infarction.

The accumulation of knowledge about hypertension and its consequences has presented physicians with a new responsibility and challenge: to control hypertension in the entire population. The physician is receiving unsolicited aid from seemingly innumerable sources, including hospitals, organizations such as the American Heart Association, the Public Health Service, and the Visiting Nurses Association, other professionals such as dentists and nurses, and even occasionally from pharmacists. The growing concern of the public about hypertension is a two-edged sword: it can certainly be beneficial in bringing the hypertension to light in individual patients, but it can also generate anxiety and confusion, problems which make the physician's job very difficult. Whether we like it or not, mass screening for hypertension is rapidly becoming a daily event in our area. Undoubtedly, screening programs are managed with varying degrees of skill, but if we as individual physicians exhibit patience, the effect of the screening program should in the long run be beneficial to the population.

(CONT. NEXT PAGE)

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Many organized programs relating to hypertension have been held in the Hampden District in the past year, and many more will be forthcoming. The most common type of program has been the screening clinic. In the typical screening clinic one to two hundred people are examined, and on the basis of a single recording of blood pressure, the individual is given appropriate advice. Each person is referred to his or her private physician, or if there is no private physician, the person is advised to engage one or to attend a clinic where follow-up care can be given. Most authorities believe that a diagnosis of fixed hypertension should not be made unless the hypertension is documented on 3 separate occasions. Therefore, the physician should measure the pressure several times before drawing firm conclusions.

The American Heart Association has selected hypertension as a problem which will receive very high priority in 1975, and the Western Massachusetts Chapter of the American Heart Association has been very active in developing programs designed to educate the public about hypertension. The Chapter has provided speakers both for the general public and for professional audiences, and it has functioned as an intermediary to facilitate certain blood pressure screening clinics.

The American Heart Association is especially interested in the problem of hypertension among the black population, since the incidence of hypertension among blacks is considerably higher than it is among whites. The Heart Association has provided funds for development of community programs designed to control hypertension. Together with the Brightwood Riverview Health Clinic, the Western Massachusetts Chapter applied for a grant from the American Heart Association, and the grant was awarded. The funds for the project have been derived in part from the National Association (American Heart Association), in part from the State Association (Massachusetts Affiliate, American Heart Association) and in largest part from the local chapter itself. During the two-year project, the goal will be to screen all residents of the area served by the Brightwood Riverview Health Clinic, and to encourage all those people with hypertension to seek appropriate care so that the hypertension can be controlled. Since most of the residents are followed in the clinic itself, control of blood pressure can also be supervised there. Physicians who help in this program are volunteers from the Heart Association.

All of the many community programs relating to hypertension will be of no use unless the individual physician is fully committed to controlling the blood pressure in all hypertensive patients. In this connection, the physician faces many practical problems. The first resides in the very definition of hypertension. Virtually all physicians would agree that any individual with a systolic pressure greater than 160 or a diastolic pressure greater than 90 is hypertensive. Systolic pressures in the range of 140 to 160 fall in the indefinite zone, particularly in the elderly patient. At the opposite end of the age spectrum, good standards for normal blood pressure have not been well established for individuals in the first and second decade of life. It is well known that the blood pressure in children is normally somewhat lower than the level in adults, but the upper limit of normal is very difficult to define.

(OVER PLEASE)

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Dr. Edward Freis, who supervised the Veterans Administration Cooperative Study, recommends that all patients with diastolic blood pressures averaging 105 mmHg. or higher (3 measurements) be treated. The basis for this recommendation is the study done by the Veterans Administration, showing that complications were prevented by control of blood pressure in those people whose diastolic blood pressure was 105 or greater. The evidence for prevention of complications in patients with diastolic pressures between 95 and 104 was somewhat less impressive, and for those patients with diastolic pressures between 90 and 94, little benefit could be shown. Therefore, it is reasonable to treat all patients with diastolic pressures of 105 or greater and most patients with diastolic pressures of 95 to 104.

The physician may well opt to observe without therapy, the patient whose diastolic pressure is in the high 90s, but whose systolic pressure is less than 150 and who has absolutely no evidence of target organ damage. There are relatively firm guidelines for treatment of hypertension in middle-aged individuals. However, it is often difficult to decide whether to treat the elderly patient, particularly when the patient has only modest, systolic hypertension. The data relating the level of blood pressure to the risk of complication have been derived from populations consisting of people under the age of 65. Is the same data relevant to the elderly? The elderly patient whose systolic pressure is less than 160 and diastolic pressure less than 95 can probably be observed safely without therapy, assuming that there is no evidence of target organ damage. Drug therapy probably should be used if the systolic pressure exceeds 160 or the diastolic pressure exceeds 95.

The patient with hypertension is usually asymptomatic and, therefore, not inclined to rush to his physician for treatment. It is incumbent upon the physician to convince his hypertensive patient that there is a medical problem, despite the absence of symptoms. It takes special effort on the part of the physician to motivate such a patient.

Once the diagnosis of hypertension is established, the physician must decide how extensively his patient should be studied to determine the etiology of the hypertension. It is well known that no underlying cause can be found for hypertension in approximately 85 to 90% of cases. On the other hand, when a specific cause is found for hypertension, it may be possible with surgery to cure the patient. For many years, it was the custom of University teaching services to subject all hypertensive patients to extensive evaluation. The yield from these evaluations was minimal, and the procedure was very expensive. Because of the growing disenchantment with the fruitless evaluation, an over reaction developed in some quarters to the point where only minimal evaluation was carried out and treatment was promptly started.

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Most physicians now take a position which is intermediate between the extremes of exhaustive evaluation on the one hand and minimal or no evaluation on the other. All patients with hypertension should have in addition to thorough history and physical examination, an electrocardiogram, chest x-ray, BUN and creatinine, electrolytes, urinalysis, and CBC. If the history or preliminary laboratory evaluation yields evidence which suggests an adrenal tumor, further evaluation is certainly necessary. A hypertensive intravenous pyelogram is part of the routine evaluation in the hands of many physicians. Others tend to reserve this test for those patients who have some specific evidence of renal disease or who are young. One test which seems to be gaining momentum is the determination of plasma renin. Dr. John Laragh of Cornell has taken the position that hyporeninemic patients with essential hypertension are at low risk for development of complications where as hyperreninemic patients are at high risk. (Brunner, H.R., Laragh, J.H. et al: NEJM 286: 441-9, 1972.) Many investigators have disputed this contention. In view of this dispute, it does not yet appear necessary to measure plasma renin in all patients with hypertension.

The age of the patient who presents with hypertension is a strong determinant of the extent of the evaluation. We now know that the typical course of essential hypertension begins with the onset of hypertension in the third or fourth decade of life, and often at the outset, the hypertension is labile, becoming fixed in the fourth decade of life. On the other hand, the presence of clearcut hypertension in patients who are in the second decade of life or early in the third decade is often a clue that there is indeed some distinct underlying problem. Therefore, exhaustive evaluation of young patients with hypertension is definitely indicated. In middle-aged patients with very severe hypertension or with hypertension which is difficult to control with medication also represents a special group and

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they should undergo the fullest possible evaluation. The middle-aged patient with moderate hypertension and normal screening tests should have a trial of pharmacologic therapy, and most of these patients will respond well.

A comprehensive discussion of all antihypertensive drugs is beyond the scope of this communication. In brief, the antihypertensive drugs can be divided into three classes: diuretics, sympathetic blocking agents, and vasodilators. Most hypertensive patients can be satisfactorily managed with diuretics alone, and therefore, the first drug administered to ambulatory patients with essential hypertension should be a diuretic, such as hydrochlorothiazide. If the blood pressure cannot be controlled with diuretic alone, one of the sympathetic blocking agents such as alphamethyldopa or reserpine is usually added to the regimen. Guanethidine is reserved for those patients who have very severe hypertension which has not responded to a diuretic and either reserpine or alphamethyldopa. Among the vasodilators used for control of hypertension are hydralazine and diazoxide. Malignant hypertension is a medical emergency, and drugs which act immediately to lower the blood pressure are indicated. In this setting the vasodilators are the drugs of choice, and since its introduction, diazoxide has become the drug most commonly used.

Propranolol has been known since its introduction into clinical use to lower blood pressure. Initially, it was thought to have this effect by virtue of its depressant action on the contractility of the heart. In recent years, however, Propranolol has been shown to inhibit the release of renin and has been advocated as the agent of choice for control of patients with hyperreninemic hypertension. The combination of Propranolol and hydralazine has been very effective. Since hydralazine is a peripheral vasodilator, its use is associated with reflex sympathetic activity resulting in tachycardia and increased cardiac output. Propranolol, a beta-adrenergic blocking agent, prevents the tachycardia and increased cardiac output which would ordinarily be associated with the administration of hydralazine.

We have learned much about hypertension in the past 20 years. We are now painfully aware that approximately half of the hypertensive individuals in our population do not even know that they have a problem. Among those who do know that they have hypertension, the incidence of good control of the hypertension is quite low and certainly less than 50%. The Veterans Administration Cooperative Study Group on antihypertensive agents showed that control of blood pressure produces a remarkable yield in terms of prevention of complication. If we can apply the lessons that we have learned to the entire population of the United States, we can control one of our leading health problems.

Ralph E. Gianelly, M.D.



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THE PAGE OF THE HDMS'S WOMAN'S AUXILIARY

As those deliciously lazy days of Summer begin, let us look back on the accomplishments of the Auxiliary in the 1974-75 season; and take a peek at an exciting 1975-76 season.

At the annual state convention held in Boston on May 27 the Auxiliary and its members received three awards. The first was a "Special Award of Merit" presented in recognition of funds raised for AMA-ERF. Our total of \$830.11 was the second highest in the state. The recruitment of 17 new members earned the auxiliary an award for the second highest number of new members in the state. The third award went to Mrs. Ellsworth Twible, President of the Hampden District 1975-76, as the volunteer giving the most hours to the Auxiliary.

It seems as though awards were the order of the day for auxiliary members. Mrs. Edward Caruso (Joanne), a past auxiliary president, was co-recipient with Sister Catherine Labouré, administrator of Mercy Hospital, of the Woman of the Year Award presented in May by the Springfield Chamber of Commerce.

Our scholarship committee is busy interviewing candidates. They have the difficult task of distributing \$4,300 to deserving students. Their decisions will be reported in a later newsletter.

The 1975-76 district officers are:

Mrs. Walton Stevens	President
Mrs. William Yorzyk	President-Elect
Mrs. Alfred Aborjaily	Recording Secretary
Mrs. Howard Trachtenberg	Corresponding Secretary
Mrs. Peter Lynch	Treasurer
Mrs. Gordon Rich	Scholarship Treasurer

These officers and their committee chairpersons have planned an exciting and informative year, beginning September 16 with the Fall meeting and luncheon. There will be a day trip to Boston on October 7. And, of course, remember in November THE WHITE CAP IS COMING, THE WHITE CAP IS COMING!

Mrs. Robert H. Nennenger (Pat)

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Woman's Auxiliary to the Hampden District Medical Society ANNUAL REPORT—1974 - 1975

As we close our activities for the 25th Anniversary year of the Auxiliary let us recall what has been accomplished, the results of many hours spent on various endeavors by a host of our members.

In September new and prospective members were invited to attend coffee hours at the home of Betsy Stevens, president-elect and membership chairman. The response was minimal but those who did attend learned about the goals of the Auxiliary from Board members present.

Stating our vital statistics for the year we are sorry to report there have been 5 deletions, 1 transfer and 8 resignations, but happy to relate that one member has been reinstated and 17 new members have been welcomed. As of this date we have a total of 287 members.

The Board of Directors met 5 times and several of them joined me at State meetings, a fall work-shop on the Immunization of Pre-School Children, a mid-winter conference where the "Finances of Volunteer Organizations" was discussed and a legislative symposium in April dealing with the problems of Malpractice insurance and the reorganization of the health regulatory system.

We have been aptly represented by Alice Cummings as 2nd Vice-President on the state auxiliary executive board and she will be serving another year in the same capacity.

Kicking off the 74-75 season our luncheon meeting in October included commemoration of our 25th year plus guest speaker, State Representative Iris Holland, whose subject was "Current Referendum Questions."

It has been a year for innovations. The first, a raffle of 2 tickets to Bermuda plus several other selective prizes which added additional fun and suspense to the 22nd annual White Cap Ball. Our thanks to Carol Yorzyk and her committee for organizing the raffle and to Grace Stirlacci and Roxy Zacarian for making the Ball such a festive occasion. We are most appreciative of the support from our members and husbands for making it possible to award \$4,300.00 for nursing and paramedical scholarships this year. The Scholarship Committee will soon be announcing the names of the recipients.

An Art Auction, a combination of a social and fund raising event to benefit A.M.A. E.R.F. was held in March. Helen Gallivan worked hard to insure success of this venture. Due to a poor attendance the financial remuneration was limited, but those who attended enjoyed themselves and many doctors purchased lovely pieces of art at very reasonable prices. It has been suggested that sometime in the future a similar endeavor may be forthcoming.

The joint dinner meeting held in December at the Yankee Pedlar Opera House was enjoyed by all who attended. Many of the doctors, taking advantage of the Costume jewelry sale, did their Christmas shopping early thus benefiting A.M.A.E.R.F.

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A.M.A.E.R.F. chairman, Joanne Janovsky, reports that to date we have contributed \$660.90 during the year through the Art Auction, sale of costume jewelry, stationery, Christmas cards, place mats, memorial cards and the contribution in honor of Doctor's Day.

Health Education chairwoman, Nancy Race and Community Health Chairwoman, Dot Mozden have been busy with plans to send Immunization leaflets home with elementary school children as part of our participation in the state wide program of the Massachusetts Medical Society's effort to educate the public on the importance of immunizing all pre-school children. New mothers will also receive these leaflets as they leave the hospital. Local radio and T.V. stations have also responded to a request for carrying public service messages on immunization.

Several auxiliaries have volunteered to assist in various capacities at the Cancer Detection Clinic for women in the Springfield area.

International Health Chairwoman, Helen Atamian, reported that items of clothing were collected for the Center for Study for Institutional Alternatives in Springfield. "Welcome Kits" containing state road maps shopping and church guides etc. have been made up for distribution to new and foreign born doctors coming to the area.

Our Health Careers Chairwoman, Alice Cummings, has seen to it that the film "Horizons Unlimited" and other requested films have been made available to all area Junior High Schools.

The Valentine Party for the elderly patients at the Springfield Municipal Hospital efficiently arranged by Roberta Krokidas, was a happy time for them and a soul-satisfying experience for the Auxiliaries who gave of themselves.

In the early spring we regretfully accepted the resignation of Ruth Hafer as Legislative Chairwoman due to other commitments, Ruth had done an excellent job keeping us posted on the many issues in the legislature regarding health services. We are happy that Cynthia Bye graciously agreed to accept the post.

Del Chabot, Publicity Chairwoman, is to be commended for the articles she wrote describing all our important activities.

As time goes on there will be a restructuring of the Auxiliary and so it behooves each of us to become involved in the development of a stronger organization.

As I conclude my term as President which has been a most enjoyable, learning experience I wish to thank the executive board, the committee chairwomen for their time and effort and the many members who supported our programs. Our thanks also to Mrs. Vivian Purdy and her staff and a special thanks to the Board of Editors of the Hampden Hippocrat for their timely coverage of our events.

My sincere best wishes to Betsy Stevens our next president, who has given me such wonderful support and assistance throughout the year.

Respectfully submitted,
Patricia Twible, President
Woman's Auxiliary
Hampden District Medical Society

Ed's Note: Well done!! Auxiliarians.

Ernest A. Byron, Jr.

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NOTICE

June 9, 1975

NOTICE

Dear Auxiliarian,

The Hampden District Medical Auxiliary is planning a day's outing to Boston on October 7.

The itinerary is exciting! A chartered bus will depart from the Longmeadow Community House at 8 A.M. (if the response is large enough a second bus will depart from the Treadway Motor Inn at the turnpike Exit 6). We will arrive in Boston at approximately 10 and be given a tour of the State Capital building by state representative Iris Holland. After the tour, the bus will take us to the Colonnade Hotel for lunch and, perhaps, Mrs. Holland will join us and speak on current matters and health legislation. After lunch the afternoon is free for shopping, sightseeing etc. At about 5:30 P.M., we will depart Boston for the trip home arriving at approximately 7:30. The overall cost of the trip is tentatively set at \$15, which will include transportation and lunch.

A flyer containing firm plans with cost and bus information will be sent in September. At that time a firm commitment and non-refundable check will be necessary. In the meantime it is necessary to determine the number who would be interested in such a trip. Therefore please return the tear-off to Mrs. Robert Bye at 170 Overbrook Rd., Long. 01106.

I am interested in attending ☐

I am **not** interested in attending ☐

Signed

Poet's Corner:

Waiting

Love is like summer lightning,
 You see it all around you.
 Look at it, watch for it, ponder it,
 Where will it strike? Will it strike me?
 Then suddenly, the bolt from the blue
 Strikes you—and you are all aglow.
 Flashing, exchanging with your lady;
 These, new electrical equations
 and charges of love.
 The strength of the bolt determines
 often
 Its length of duration—for some of us
 It is momentary and fleeting, for others
 Lasting—permanent. At times for the
 better,
 At times for the worse, Alas, Alack
 I am waiting for that bolt!

But bless Dan's bow and arrow—by
 Thor's bolts,
 I think I've been hit!!
 These passions new, Are passions
 old.
 Strange to me, well known to others.
 To me—Life's mystery—To them,
 its answer.
 Guarded by me, Yet shared by broth-
 ers.
 Attempted by me—But successfully
 by poets told.

1945 — WES

Bird Feeder's Lament

What the Grosbeak does come Eve-
 ning
 I haven't an ideah,
 But from sunrise until sunset
 I'm supporting him right heah.

HNS

Epitaph for an Imbiber

I don't know how much of it
 Whiskey and gin did,
 But he may be thought of
 As Gone With The Winded.

HNS

Urine Isn't Everything

Title of article in JAMA Mar. 3, 1975
 p978

Urine isn't everything,
 The A.M.A. alerts us;
 We welcome knowledge journals
 bring,
 It's ignorance that hurts us.
 I showed the piece to Farmer Brown,
 Who sneered at me, because,
 His comment, throwing shovel down,
 "I never thought it was."

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Letter to the Editor

To the Editor:

I take strong exception to Dr. Ibrahim B. Syed's remarks as written and expressed in the May 1975, issue of the *Hampden Hippocrat*. He states that "America is no longer the land of opportunity," yet recently he came to our country and through scholarships and aids provided by our citizens he has established himself here. There is no country or system that is perfect. He decries the plight of our senior citizens who often go hungry and eat pet food. I wonder what he has done about his former country where he came from where children and infants die by the ten thousands from hunger and neglect? He talks glibly of our political failures and shortcomings. I don't deny the plight of our immediate political stature, but look to our long history of two centuries for the freedoms of religion and expression of individual rights which *no country* in the world has equaled.

He advocates National Health Insurance for our country. Has he looked upon the European Countries where there is National Health Insurance, how in England a patient has to wait two years for elective surgery and his health care is a matter of an assembly line? By the way, leprosy, malaria and typhoid are rare diseases in our country.

I think Dr. Syed has lost sight of the trees for the forest and his opinion of our country is viewed with short sighted glasses. We would all like to live in a Shangri-la but we don't—I am dedicated to improve our system as many other Americans, but it does take time and in the meantime I am most grateful and proud to be an American.

S.A. Zacarian, M.D.

Ed's Note: A reply and rebuttal will be forthcoming in the Sept. issue.

Paramedical Organizations of Note:

The Springfield Boys' Club-Carew Hill Girls' Club is currently developing a music program for boy and girl members ages 10-15. Plans call for the organization of varied singing and instrumental groups, as well as guitar lessons and a course in songwriting, believed to be the first of its kind ever offered in this area. The director of this program is Todd Hosman, a recent graduate of Hampshire College and son of Chicopee physician I. Daniel Hosman.

The music program is directed primarily towards low-income, underprivileged children, and all performances conducted through this program will be done so on a non-profit basis. It is expected that such performances will be presented for audiences at local hospitals, civic groups and other institutions of this general nature.

One of the most immediate problems confronting the program there is the lack of a piano, as well as many other types of musical equipment. Persons interested in making such donations to this charitable agency, or those who would offer their services in order to assist the community-oriented music program are encouraged to contact Mr. Hosman at 732-7201, Monday through Friday, between the hours of 6:00 and 9:30 P.M. The Clubs are located at 481 Carew Street in Springfield.

Ed's Note: A worthwhile outlet for your energy or old piano!

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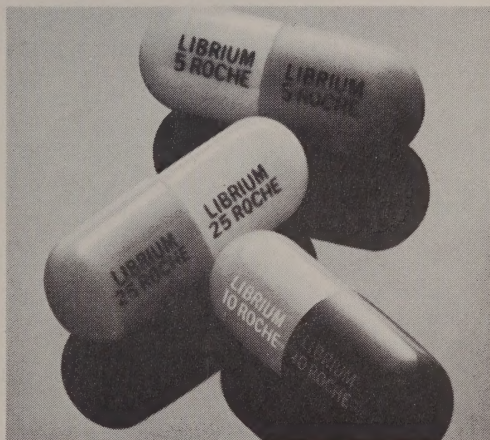
ORAL: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six.

INJECTABLE: Keep patients under observation, preferably in bed, up to three hours after initial injection; forbid ambulatory patients to operate vehicle following injection; do not administer to patients in shock or comatose states; use reduced dosage (usually 25 to 50 mg) for the elderly or debilitated and for children age twelve or older.

ORAL AND INJECTABLE: Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating compounds such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests ad-

Please see following page.



visable during protracted therapy.

With the injectable form, isolated instances of hypotension, tachycardia and blurred vision have been reported; also hypotension associated with spinal anesthesia, and pain following I.M. injection.

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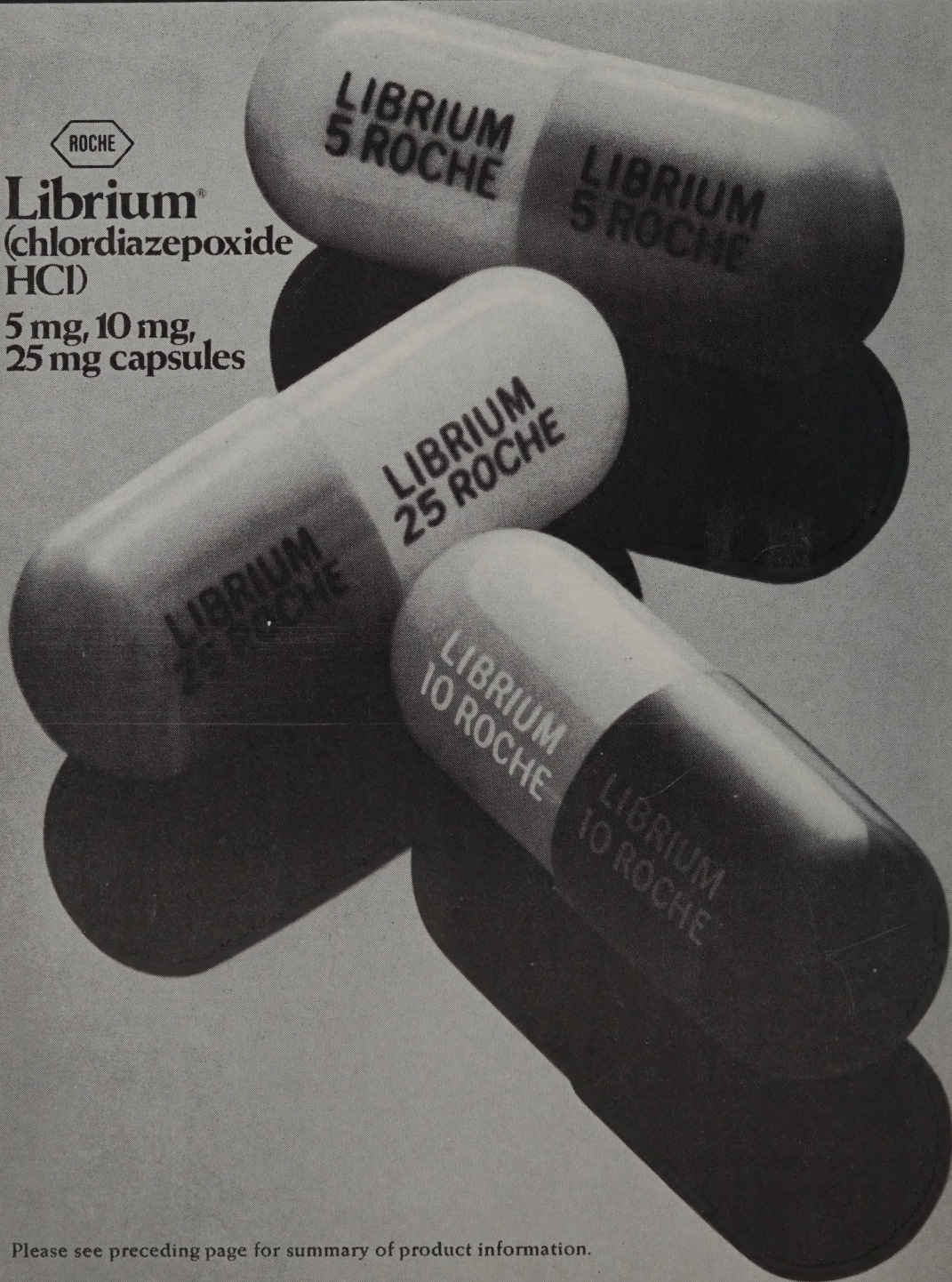
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